Form I

Fee: $25.00

KENTUCKY BOARD OF PHARMACY
SPINDLETOP ADMINISTRATION BLDG., STE 302
2624 RESEARCH PARK DRIVE
LEXINGTON, KY 40511
PHONE 859-246-2820 FAX 859-246-2823

APPLICATION FOR REGISTRATION AS A PHARMACIST INTERN

Name: _____ _____
(Last) (First) (Middle) **Social Security Number**

Address: _____ _____
(Street) (Phone)

_____ _____
(City) (State) (Zip) (Date of Birth)

A recent head and shoulders Passport Photograph must be attached. (No proof copies, plastic ID, or digital computer images are acceptable.

□ I have been accepted to enter the _____
(Name of School or College of Pharmacy)
and shall enroll for the term beginning _____ with an anticipated date of graduation of _____.
(Date) (Date)

□ I have attached a copy of my FPGEC certificate. **(Foreign graduates only)**

I understand that I cannot compound or dispense drugs or medicines except when performed under the immediate personal supervision of a pharmacist, and that I cannot be left in charge of a pharmacy at any time. I am aware that this registration is valid for six (6) years from the date of issue unless I am no longer enrolled in a School or College of Pharmacy.
I have not: (1) been convicted of a felony; (2) been convicted of violation (s) of any drug laws; (3) abused a prescription drug; (4) misappropriated or illegally used prescription drugs or other pharmacologically active agents; (5) chronically or persistently abused alcohol.
I understand that in the event I am charged with or treated for any of the above, the Kentucky Board of Pharmacy must be notified within thirty (30) days and may initiate a review and take appropriate action to protect the citizens of the Commonwealth during this registration.
I have attached a copy of my letter of acceptance from

_____.
(Name of School or College of Pharmacy)

_____ _____
(Date) (Signature)

(FOR BOARD USE ONLY – LEAVE BLANK)

Registration Number: _____ Date Issued: _____

Fee Received: $_____